NEWPORT HOSPITAL
A Lifespan Partner
11 FRIENDSHIP STREET
NEWPORT, RHODE ISLAND 02840-2299
(401) 845-1150 Fax: (401) 848-6009

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION MEDICAL RECORD DEPARTMENT/REMOTE MEDICAL OFFICES

Date: _____ Time: _____ Phone Number: _____

Name of Patient: _____ Date of Birth: _____

I hereby authorize Newport Hospital to disclose and release to:

_____
(Name of person/place/institution)

_____
(Address)

The following confidential health care information about: _____
(My, my child's, my ward's etc.)

hospitalization and/or out patient examination/treatment:

_____
(Dates of treatment and/or specific information required)

for the purpose(s) of: _____
(Reason for request, i.e., how is information to be used)

Please check one: I hereby

☐ **Consent** ☐ **Refuse**

to the release of confidential information concerning: mental illness, alcohol and/or drug use, sexual abuse, venereal disease, AIDS or HIV test results.

I understand that my records are protected under the Federal Confidentiality Regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

Any information to be released or received that is authorized by my consent evidenced by this document shall not be given, transferred or relayed in any manner to any other person, either in an individual or representative capacity, without an additional written consent.

I understand that I may withdraw this consent by giving written notification to Newport Hospital at any time prior to the disclosure or release of the information. In the absence of my prior withdrawal, this consent will expire 90 days after it is signed.

I confirm that I have read the above, fully understand it and have no further questions.

_____ _____
Signature of Patient/Authorized Representative Date signed

_____ _____
Witness to Signature of Patient/Authorized Representative Relationship

Form #875-287 (Revised 5/2003)